

## Department of Veterans Affairs

## § 51.110

(7) For the maintenance of comfortable sound levels.

(Authority: 38 U.S.C. 101, 501, 1710, 1741–1743)

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900–0160)

[65 FR 968, Jan. 6, 2000, as amended at 74 FR 19434, Apr. 29, 2009]

### § 51.110 Resident assessment.

The facility management must conduct initially, annually and as required by a change in the resident's condition a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity.

(a) *Admission orders.* At the time each resident is admitted, the facility management must have physician orders for the resident's immediate care and a medical assessment, including a medical history and physical examination, within a time frame appropriate to the resident's condition, not to exceed 72 hours after admission, except when an examination was performed within five days before admission and the findings were recorded in the medical record on admission.

(b) *Comprehensive assessments.* (1) The facility management must make a comprehensive assessment of a resident's needs:

(i) Using the Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument Minimum Data Set, Version 3.0; and

(ii) Describing the resident's capability to perform daily life functions, strengths, performances, needs as well as significant impairments in functional capacity.

(2) *Frequency.* Assessments must be conducted—

(i) No later than 14 days after the date of admission;

(ii) Promptly after a significant change in the resident's physical, mental, or social condition; and

(iii) In no case less often than once every 12 months.

(3) *Review of assessments.* The nursing facility management must examine each resident no less than once every 3 months, and as appropriate, revise the resident's assessment to assure the continued accuracy of the assessment.

(4) *Use.* The results of the assessment are used to develop, review, and revise the resident's individualized comprehensive plan of care, under paragraph (d) of this section.

(c) *Accuracy of assessments.* (1) Coordination—

(i) Each assessment must be conducted or coordinated with the appropriate participation of health professionals.

(ii) Each assessment must be conducted or coordinated by a registered nurse that signs and certifies the completion of the assessment.

(2) *Certification.* Each person who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

(d) *Submission of assessments.* Each assessment (initial, annual, change in condition, and quarterly) using the Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument Minimum Data Set, Version 2.0 must be submitted electronically to VA at the IP address provided by VA to the State within 30 days after completion of the assessment document.

(e) *Comprehensive care plans.* (1) The facility management must develop an individualized comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's physical, mental, and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the following—

(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under § 51.120; and

(ii) Any services that would otherwise be required under § 51.120 of this part but are not provided due to the resident's exercise of rights under § 51.70, including the right to refuse treatment under § 51.70(b)(4) of this part.

(2) A comprehensive care plan must be—

(i) Developed within 7 calendar days after completion of the comprehensive assessment;

(ii) Prepared by an interdisciplinary team, that includes the primary physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and

(iii) Periodically reviewed and revised by a team of qualified persons after each assessment.

(3) The services provided or arranged by the facility must—

(i) Meet professional standards of quality; and

(ii) Be provided by qualified persons in accordance with each resident's written plan of care.

(f) *Discharge summary.* Prior to discharging a resident, the facility management must prepare a discharge summary that includes—

(1) A recapitulation of the resident's stay;

(2) A summary of the resident's status at the time of the discharge to include items in paragraph (b)(2) of this section; and

(3) A post-discharge plan of care that is developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment.

(Authority: 38 U.S.C. 101, 501, 1710, 1741–1743)

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900–0160)

[65 FR 968, Jan. 6, 2000, as amended at 74 FR 19434, Apr. 29, 2009; 77 FR 26184, May 3, 2012]

#### § 51.120 Quality of care.

Each resident must receive and the facility management must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

(a) *Reporting of Sentinel Events*—(1) *Definition.* A sentinel event is an adverse event that results in the loss of life or limb or permanent loss of function.

(2) Examples of sentinel events are as follows:

(i) Any resident death, paralysis, coma or other major permanent loss of function associated with a medication error; or

(ii) Any suicide of a resident, including suicides following elopement (unauthorized departure) from the facility; or

(iii) Any elopement of a resident from the facility resulting in a death or a major permanent loss of function; or

(iv) Any procedure or clinical intervention, including restraints, that result in death or a major permanent loss of function; or

(v) Assault, homicide or other crime resulting in patient death or major permanent loss of function; or

(vi) A patient fall that results in death or major permanent loss of function as a direct result of the injuries sustained in the fall.

(3) The facility management must report sentinel events to the director of VA medical center of jurisdiction within 24 hours of identification. The VA medical center of jurisdiction must report sentinel events by calling VA Network Director (10N 1–22) and Chief Consultant, Office of Geriatrics and Extended Care (114) within 24 hours of notification.

(4) The facility management must establish a mechanism to review and analyze a sentinel event resulting in a written report no later than 10 working days following the event. The purpose of the review and analysis of a sentinel event is to prevent injuries to residents, visitors, and personnel, and to manage those injuries that do occur and to minimize the negative consequences to the injured individuals and facility.

(b) *Activities of daily living.* Based on the comprehensive assessment of a resident, the facility management must ensure that—

(1) A resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's ability to—

(i) Bathe, dress, and groom;

(ii) Transfer and ambulate;

(iii) Toilet;

(iv) Eat; and